

DISABILITY CERTIFICATE FOR ATTENDANT CARE

I, \_\_\_\_\_, have examined and/or treated \_\_\_\_\_  
for injuries sustained in a motor vehicle accident, which occurred on  
\_\_\_\_\_. It is my opinion that the aforesaid patient requires  
attendant care, as he/she needs assistance with the following:

- |   |  |
|---|--|
| <input type="checkbox"/> Bathing and/or Tub Transfers         | <input type="checkbox"/> Personal Grooming         |
| <input type="checkbox"/> Room, Bed and/or Chair Transfers     | <input type="checkbox"/> Dressing                  |
| <input type="checkbox"/> Bathroom and/or Bedpan               | <input type="checkbox"/> Driving/Transportation    |
| <input type="checkbox"/> Temperature and/or Vital Sign Checks | <input type="checkbox"/> Medication                |
| <input type="checkbox"/> Carrying, Fetching and/or Lifting    | <input type="checkbox"/> Bandages and/or Dressings |
| <input type="checkbox"/> Other (please specify): _____        |  |

It is my opinion that the above patient/claimant is/was disabled:

From \_\_\_\_\_ to \_\_\_\_\_ at a rate of \_\_\_\_\_ hours per day.

It is my opinion that he/she will continue to need assistance with the  
above due to the accident-related injuries for \_\_\_\_\_ weeks or months  
(circle one).

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Phone: \_\_\_\_\_ Tax ID#: \_\_\_\_\_